

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

**CELEBREX** (celecoxib)

Patient name: \_\_\_\_\_ Medicaid or SS# \_\_\_\_\_

Physician Name: \_\_\_\_\_ Contact person: \_\_\_\_\_

Phone#: \_\_\_\_\_ Ext. and options \_\_\_\_\_ Fax# \_\_\_\_\_

Pharmacy \_\_\_\_\_ Pharmacy Phone#: \_\_\_\_\_

**All information to be legible, complete and correct or form will be returned**

---

**CIRCLE APPROPRIATE CO-COMMITTANT DIAGNOSIS:**

1. GERD
2. Barrett's Syndrome
3. Peptic Ulcer
4. Gastro-hypersecretory condition or gastric bleeding caused by other NSAIDS (**DOCUMENTATION FROM PROGRESS NOTES REQUIRED**)
5. History of ulcers
6. Concomitant anticoagulant therapy
7. Concomitant oral corticosteroid therapy
8. Failure on 3 other NSAIDS (**DOCUMENTATION FROM PROGRESS NOTES REQUIRED**)

**INFORMATION:**

Authorization is not needed for ages 65 and above

**TELEPHONE PRIOR MAY BE USED FOR:**

- ▶ Analgesic for **10 days** with telephone request from physician's office or pharmacy

**AUTHORIZATION:**

1 year

**RE-AUTHORIZATION:**

Telephone request from physician's office or pharmacy

**The Department regards adequate clinical records as essential for the delivery of quality care, such comprehensive records are key documents for post payment review. Your authorization certifies that the above request is medically necessary, meets the Utah Medicaid criteria for prior authorization, does not exceed the medical needs of the member and is supported in your medical records.**

Physician Signature \_\_\_\_\_ Date of Submission \_\_\_\_\_